Alaska Medicaid Prior Authorization Request Form

Synagis

for RSV Season November 28, 2012 through May 14, 2013

PRESCRIBER USE ONLY**

MAGELLAN MEDICAID ADMINISTRATION

Fax this request to: (888) 603-7696 **Questions?** Call Magellan Medicaid Administration at (800) 331-4475

Or mail this request to: Medicaid PA Unit, 14100 Magellan Plaza, Maryland Heights, MO 63043

REQUESTOR	Must be requested by prescriber. See below.	
RECIPIENT	Last Name, First Name, Middle I.:	
DOB:	Medicaid ID:	Sex: ☐ Male ☐ Female
PRESCRIBER	Name:	NPI: - - - - - - - - - -
Phone: ( )		Fax: ( )
REQUEST	Synagis 50mg NDC 60574411401 QTY -	Requested Start Date / /
	Synagis 100mg NDC 60574411301 QTY -	Requested Start Date / /

***** All sections must be completed or the request will not be approved*****

RATIONALE FOR PRIOR AUTHORIZATION http://hss.state.ak.us/dhcs/pharmacy/medpriorauthoriz.htm

Gestational Age: _____Weeks_____Days *Note: Weeks and days are both required* **Weight in kilograms** _____

[ ]Diagnosis of Chronic Lung Disease (formerly called bronchopulmonary dysplasia) **AND** child must be < 24 months of age at onset of season on Nov. 28 (DOB after 11/28/10) **AND** child has required medical treatment in the preceding 6 months.
Check/Complete all that apply:
- [ ]Oxygen most recent date administered: _____
- [ ]Corticosteroids most recent date administered: _____
- [ ]Bronchodilators most recent date administered: _____
- [ ]Other - most recent date administered: _____

The infant may be approved for no more than 6 monthly doses of palivizumab

[ ]Hemodynamically significant cyanotic or acyanotic Congenital Heart Disease (CHD) AND child must be < 24 months of age at onset of season on November 28 (DOB on or after 11/28/10).
The infant may be approved for no more than 6 monthly doses of palivizuma.
If the child undergoes cardio-pulmonary bypass surgery during the RSV season, an extra post-operative dose can be authorized.
[ ]Cardio-pulmonary bypass surgery; Date: _____

[ ]Child is ≤ 12 months of age on November 28 (DOB after 11/28/11) **AND**
- [ ]Gestational age ≤ 28 weeks, 6 days,

OR

[ ]Child is ≤ 12 months of age on November 28 (DOB after 11/28/11) **AND** diagnosed with:
- [ ]Congenital abnormalities of the airway **OR** [ ]Neuromuscular condition requiring handling of respiratory secretions

The infant may be approved for no more than 6 monthly doses of palivizumab

[ ]Child is ≤ 6 months of age on Nov. 28 (DOB after 5/28/12) **AND** gestational age is 29 weeks, 0 days through 31 weeks, 6 days.
The infant may be approved for no more than 6 monthly doses of palivizumab

[ ]Child is ≤ 3 months of age on Nov. 28 (DOB on 9/1/12 or after) **AND** gestational age is 32 weeks, 0 days through 34 weeks, 6 days*, **AND:**
- [ ]Child attends daycare, **OR**
- [ ]Child resides in a home with another child < 5 years of age **OR**
- [ ]Child resides in a crowded living environment (≥ 3 children per bedroom or ≥ 7 people per household) **OR**
- [ ]Child resides in a home with lack of running water

*The infant in this category will qualify for monthly doses **only** up until 3 months (90 days) of age.*

Prescriber's Signature	Date